THE MEDICAID MANAGEMENT EXCHANGE-MMX

ADMINISTRATIVE NOTES ON MEDICAID MANAGEMENT

April 1979 (for administrative use only) ISSUE #5

CLEARINGHOUSE

RA 412.4 .I57 no.5 (1979: Apr)

Schaeffer Sets MMIS Goals

THE PROGRAM MUST INCREASE EFFICIENCY in service delivery and get rid of waste in order to restore public confidence in Medicaid, Leonard Schaeffer, HCFA Administrator, stressed in a speech to MMIS conferees in Albuquerque. To accomplish this, a management-oriented MMIS is necessary: one where managers can use MMIS reports to spot problems and pursue solutions, and share management techniques and experiences. "It's the best tool we have for improving management," said Schaeffer. He indicated that improved management will also enable HCFA to better respond to legislative requests for program information.

"Beginning today...we're going to refocus our efforts in the MMIS field from process orientation to outcome-oriented performance standards," announced Schaeffer. Progress toward this goal will depend on State participation in the National Technical Advisory Group (NTAG), which he expects will be a primary vehicle for developing standards and techniques for evaluating performance. He added, States will be reevaluated on a regular basis for certification of individual MMIS modules to receive their 75% matching funds. Failure to meet the performance standards will result in loss of certification. Schaeffer stressed that these standards will be developed prospectively after consultation with the States, and will be sensitive to budget processes.

Schaeffer promised States, "In terms of our support of your efforts, we will be highlighting State achievements whenever we can...in Congressional hearings, in press releases, in statements by the Secretary..." Schaeffer concluded that the Federal government will be committed to listen to what States have to say, as well as offer assistance and support so that everyone can work together toward creative management of MMIS.

Alternatives Report Available

COPIES OF Alternatives to Institutionalization: an Evaluation of State Practices are available to State Medicaid agencies from the Institute for Medicaid Management (IMM). Developed for HCFA by the National Institute for Advanced Studies, this manual discusses the development of alternate care programs to reduce or prevent inappropriate institutionalization.

The manual should assist State programs in reviewing actions needed for a successful program, and potential problems and pitfalls.

For copies of the report, write: Medicaid Management Clearinghouse, IMM/MMB/HCFA, 4030 M.E. Switzer Bldg., 330 "C" Street, S.W., Washington, D.C. 20201.

MMIS UPDATE

VIRGINIA, THE NEW YORK CITY portion of New York, CALIFORNIA, and NEBRASKA have received Medicaid Management Information System (MMIS) certification. Twenty-three States now receive 75% Federal matching for mechanized claims processing systems.

The Medicaid Bureau certified Virginia's system, with the Computer Company as fiscal agent, retroactive to December 1, 1977. CALIFORNIA's MMIS received certification retroactive to January 1, 1978. However, CALIFORNIA will replace their current system, run by Blue Cross/Blue Shield, with a system to be installed by Computer Sciences Corporation in 1979 and 1980.

KANSAS and VERMONT have been reviewed, but not yet certified. The drug portion of NORTH CAROLINA's MMIS has also been reviewed for certification.

National Technical Advisory Group

A NATIONAL TECHNICAL ADVISORY GROUP (NTAG), formed at the Albuquerque MMIS conference, will involve States in MMIS improvements and performance standards. Chaired by Paul Allen from Michigan, the NTAG includes representatives from Oklahoma, Idaho, New Jersey, Georgia, Texas, Pennsylvania, Michigan and Minnesota. The HEW MMIS Task Force, led by Robert Nakamoto, will work with the NTAG to develop MMIS performance standards. Other NTAG objectives include: 1) sharing new procedures and techniques; 2) exchanging information; and 3) increasing interaction among MMIS users.

In response to the Inspector General's recommendations, the MMIS Steering Committee and the Task Force were established to mobilize action for improving MMIS effectiveness.

MMIS Conference

MMIS IS A VALUABLE management tool that must constantly be maintained and improved, according to representatives from 30 States during the national conference on MMIS in Albuquerque, New Mexico, January 23-25. This conference provided a means for exchange of information and experiences on how to effectively use data and reports produced by the MMIS.

Participants emphasized the need for knowledgeable MMIS managers who can handle technological changes and recognize the necessity of a flexible and coordinated system. State MMIS representatives shared their problems with implementation, discussed corrective steps to maximize efficiency, and presented new applications beneficial to their Medicaid programs. Specific topics included NEW JERSEY's Medicaid Exception Reporting System (MERS) which permits the user to readily control and understand output, and an S/UR II, tailored specifically to the needs of MINNESOTA. In another MMIS presentation, GEORGIA described its nursing home subsystem as their most advanced in meeting user needs.

Nevada, Hawaii to Release RFPs

HAWAII IS IN THE PROCESS of developing a Request for Proposal (RFP) to rebid its MMIS contract. The RFP will be released Spring or Summer of this year, and may include an EPSDT case management system as part of the contract.

NEVADA will release an RFP for the data entry and provider relations portion of its MMIS sometime after April 1. Data processing will be performed by State staff. Nevada expects to have its MMIS operational by July 1980.

Bill Processing System Test

THE MEDICAID BUREAU has helped install the Medicaid Bill Processing System Test (BPST) in six States: ARKANSAS, KANSAS, NEBRASKA, NEVADA, NEW MEXICO, and WISCONSIN. Installation is underway in two additional States, not yet named for publication. The BPST tests a State claims processing system by running fictitious physician claims with common erroneous billing practices through a State's payment system. In all, nearly two-thirds of Medicaid agencies have expressed interest in BPST.

Florida Moves Toward MMIS

FLORIDA IS PROCESSING claims faster and more efficiently, as Systems Development Corporation, the State's fiscal agent, nears completion of the MMIS development process. Already, 97% of all claims are being processed within 20 days. In addition, providers are receiving weekly, rather than bi-monthly payments, and providers no longer need to receive transaction numbers from the State before billing. A certification review of the system is scheduled for March.

Idaho MMIS

IDAHO'S MMIS MORE THAN PAID for its own cost over the first half year of operation, reports the State Medicaid agency. In addition, the MMIS has tightened program control and served as an early warning system for State administrators, detecting problem areas months sooner than before.

Total payment cutbacks due to MMIS edits for the first nine months of operation (Jan-Sept 1978) were about $2.8 million, almost 10% of program expenditures, and a significant increase over pre-MMIS cut-backs. MMIS was particularly effective in saving costs by detecting duplicate claims. In addition, third party liability efforts saved $300,000.

New York MMIS

HEW SECRETARY JOSEPH A. CALIFANO announced Federal certification of the NEW YORK CITY portion of that State's MMIS at a January 6 press conference in New York City. The State estimates the system generated savings of $29 million in the first year of operation through denial of unjustified claims. When MMIS is fully operational, the Medicaid program in New York City will realize an estimated savings of more than $100 million annually. In addition, the MMIS has dramatically increased provider participation, contributed to streamlined eligibility files, and achieved a 10 day turnaround for payment of clean claims. The system will be fully operational March 1979.

In a further move, NEW YORK STATE awarded Bradford National Corporation, fiscal agent for New York City, the Upstate New York MMIS contract. The new contract calls for full implementation of MMIS outside New York City by December 1980, with counties entering the system by region. However, before MMIS can be fully installed, the State must complete its Welfare Management System (WMS), a computerized eligibility system.

The Statewide MMIS will relieve districts in New York of claims processing, issuing Medicaid cards, and statistical and financial reporting. However, districts will continue to determine eligibility. The Statewide system is expected to cut Medicaid costs by up to $200 million per year.

Missouri MMIS

MISSOURI HAS CHOSEN Electronic Data Systems Federal Corporation (EDSF) to install an MMIS. Although the contract still needs Federal approval, the State hopes to have the system in place by the end of July 1979.

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Medicaid Fraud Control Unit Update

AS OF JANUARY 1979, the Health Care Financing Administration (HCFA) has certified 21 State Medicaid Fraud Control Units. These units, which meet the criteria of Section 17 of PL 95-142 (the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977), are eligible for 90% Federal matching. Some 794 professional investigators, auditors and lawyers in these units are expected to undertake 3,856 fraud investigations over the next year.

States which have established Fraud Control Units are:

ALABAMA	NEW JERSEY
ARKANSAS	NEW MEXICO
CALIFORNIA	NEW YORK
COLORADO	NORTH CAROLINA
CONNECTICUT	OHIO
HAWAII	PENNSYLVANIA
IDAHO	RHODE ISLAND
LOUISIANA	VERMONT
MASSACHUSETTS	WASHINGTON
MICHIGAN	WISCONSIN
NEBRASKA	

Other States have indicated active interest and it is anticipated that in all, 30-35 States will set up such units.

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Premium to Increase in Medicare Part B

THE MONTHLY MEDICARE Part B premium will increase from $8.20 to $8.70, effective July 1, due to higher health care costs. The total cost of benefits under Medicare Part B is expected to increase from about $8.2 billion in FY 1979 to $9.6 billion in FY 1980.

Michigan Passes Nursing Home Law

MICHIGAN HAS AMENDED its nursing home licensure requirements to protect patient rights, assure quality of care, and prevent fraud. Under a new patient bill of rights, patients may: appeal transfers from one institution to another; exercise decisions on their own medical treatment; and file lawsuits against the homes. The law now sets standards for the safety of patients' mail and belongings, and provides approved organizations access to nursing home patients. Mental, emotional and physical abuse or neglect of patients is prohibited.

The law also sets minimum training standards for nonlicensed nursing home personnel, although the standards are not a prerequisite for employment. The Department of Health is authorized to conduct random competency tests to enforce these standards. The law also calls for unannounced inspections or survey visits of nursing homes, and prohibits fraud, kickbacks and misleading advertising by the nursing homes.

This legislation provides the Health Department with additional flexibility and tools for enforcing licensure laws. Short of denying licensure, the Department can limit admissions to a facility, or the number of patients in that facility, and has the power to fine homes up to $10,000 for disregarding Health Department orders or licensure requirements.

The new law also charters a 15 member task force to review the operations and enforcement of licensure and certification requirements, to hear and evaluate complaints, and to recommend changes in the law. The task force, which will play the role of an ombudsman, will meet at least six times a year.

Legislative Ledger

NEW LEGISLATIVE CYCLE began with the convening of the 96th Congress January 15, 1979. New chairmen will head two subcommittees with jurisdiction over Medicaid legislation: Henry Waxman (D-CA) replaces retiring Paul Rogers (D-FL) as Chairman of the House Commerce Committee's Subcommittee on Health and the Environment; and Charles Rangel (D-NY) is now Chairman of the Subcommittee on Health, House Ways and Means Committee, replacing Dan Rostenkowski (D-IL). Bob Ekhardt (D-TX) replaces John Moss (D-CA), who retired, as chairman of the House Committee on Oversight, which reviews Medicaid program activities.

Major legislative initiatives in the Administration's FY 1980 budget include Hospital Cost Containment and the Child Health Assurance Program (CHAP), although to date the revised CHAP bill has not been submitted to Congress. The Hospital Cost Containment bill contains a voluntary cost containment goal, limiting growth in hospital expenditures to 9.7% annually. A standby, mandatory cost containment program would become effective if the voluntary program has not succeeded by the end of 1979.

CHAP

It appears that the Administration's CHAP bill will propose that all categorical restrictions on eligibility for children and pregnant women be removed. In addition, a minimum income level would be set somewhere around 55% of the poverty line ($3,600 for a family of four, 1978) for these groups. Coverage of additional children 18-21 would be a State option. These changes would extend eligibility to over 2 million additional poor children and 100,000 low-income pregnant women.

Also, CHAP would make dental, vision, hearing and ambulatory mental health mandatory State services for all eligible children. Performance standards based on the percentage of children in continuing care, or screened and treated, would be a basis for a graduated Federal match including incentives and penalties. However, for the first 18 months, no penalty would be assessed, so States can initiate programs and increase eligibility. Another provision calls for enrollment and incentives for providers who agree to act as a source for continuing care for children.

Other Bills

Other initiatives in the budget include: a provision to extend Medicare and Medicaid eligibility for three years for persons no longer entitled to cash payment because their disability had ended; and the elimination of chiropractic benefits under both programs.

The Clinical Laboratory Improvement Act (CLIA) and the Medicare and Medicaid Administrative and Reimbursement Reform Act (Talmadge bill), both of which died at the close of the 95th Congress, are expected to be resubmitted. We will supply details on these bills when they are introduced. Also, HCFA is considering legislation to increase enrollment of HCFA beneficiaries in HMOs, through changes in reimbursement.

Aside from hearings on these bills (and possibly National Health Insurance), hearings may also occur this session on home health, patient rights for those in long term care institutions, Medicaid Quality Control, Professional Standards Review Organizations (PSROs), and patient confidentiality. ■

IMM Seeks Information

SEVERAL STATES HAVE recently asked the IMM for information on good State management practices for dealing with erroneous expenditures and program abuse. State managers with ideas or good programs to share with other States are asked to contact the Institute.

Specifically, the IMM is soliciting information about management techniques to:

- detect and prevent program abuse (rather than fraud), including types of cases to look for, S/UR unit interface with fraud control units, methods for developing cases and taking administrative action, etc.; and

- identify and correct operational or systems problems that contribute to erroneous expenditures, such as QC data analysis for corrective action planning, data exchanges to verify beneficiary assets or third-party coverage, etc.

The Institute realizes considerable work has been done in these areas; however, there is a lack of centralized resource material.

The IMM can include highlights of good State practices or achievements in the MMX, or publish longer descriptive articles in the Journal. IMM can also work with State staff to document technical or detailed information about exemplary State programs for separate publication.

Please send your ideas, articles or documentation to: Medicaid Management Clearinghouse, IMM, Room 4030 Switzer Bldg., 330 C St., S.W., Washington, D.C. 20201, or call Ginger Hale at 202-245-6575.

Progress Through Partnership

IMM

Institute for Medicaid Management

Personnel

New Single State Agency Heads

Mr. Emmett S. Roberts, Florida
Mr. John D. Pratt, Massachusetts
Mr. David R. Freeman, Missouri
Mr. Charles R. Buck, Jr., Maryland
Mr. E. D. Warnsholz, Nebraska
Ralph Disibio, Ed.D., Nevada
Mr. Lawrence B. Ingram, New Mexico
Ms. Helen O'Bannon, Pennsylvania
Mr. Vern C. Woodard, South Carolina
Mr. David W. Forinash, West Virginia

New State Medicaid Directors

Barry Dorfman, M.D., California
Ms. Bonnie Smith, Louisiana
Mr. Lawrence Ford, New Hampshire

HCFA Personnel Changes

DENNIS SIEBERT, former Acting Director of HCFA's Office of Professional Standards Review Organizations (OPSRO/HSQB), has been named Director of that office. Siebert succeeds Michael Goran, M.D., who resigned last fall.

Several staff changes have occured among Division Directors in the Medicaid Bureau (MMB) Central Office. John Berry is the new Director of the Division of Quality Control; Sam Guida, Division of State Management; and Mary Kenesson, Institute for Medicaid Management. Arthur Pergam is Director of the Corrective Action Project; John Mullen is Acting Director of Division of Information Systems, replacing Robert Nakamoto, who was named Deputy Assistant Director of the Office of State Operations.

Bea Moore, Assistant Director, Office of Child Health, will be moving soon to a new position with the Children's Bureau in the Office of Human Development Services/HEW; Mary Tierney has been named Acting Deputy Director. Peg Schnoor has returned from HCFA to MMB to head the Policy Coordination Staff. ■

Michigan Hotline Success

ON JANUARY 16, 1979 MICHIGAN's Medicaid provider hotline received its 500,000th inquiry. Begun in 1972, the hotline is usually the first contact the medical provider has with the Medicaid program, and supplies information on billing, enrollment, covered services, prior authorization, program policy, and other subjects.

Eight communications specialists respond to telephone inquiries and research provider problems. To run an efficient hotline, the staff requires complete program knowledge, which is gained through six months to one year of intensive training. In turn, hotline experience has benefitted the staff in new assignments, where their effectiveness has improved program management.

Provider involvement in Michigan is discussed in detail in the Journal for Medicaid Managemnt, Vol. 1, Number 2, Summer 1977.

Massachusetts Starts Foster Care Project

MASSACHUSETTS IS LAUNCHING a two-year pilot project to provide foster care to elderly and disabled beneficiaries who would otherwise be admitted to long term care facilities. Under this project, foster families will be designated personal care attendants. The beneficiary's SSI income will pay for room and board, less $78 per month as personal needs funds, and the Medicaid program will reimburse the foster family at $4.00 per hour for its services as personal care attendant. These services must be prescribed by a physician and supervised by a nurse from a home health agency, and will include assistance with medications and activities of daily living. The project is aimed at substituting a family-type setting for beneficiaries requiring ICF level of care.

Intgration Project Status Report

HCFA ESTABLISHED 20 integration projects in the Spring of 1978 as part of its drive to unify the Medicare and Medicaid programs. These projects, selected from 40 common program areas identified by an HCFA task force, address three basic topics: management (8 projects); claims processing (8); and reimbursement/ accounting (4). There has been some project substitution since then, and new projects are also under consideration.

For each project, a team has been created consisting of personnel from the bureau(s) most concerned with the subject matter. Each bureau (Medicaid, Medicare, Health Standards and Quality) is represented by a number of project managers. The State Medicaid Director's Council has formed an integration project steering committee and work groups, and together with the American Public Welfare Association advises and assists on the projects.

To date, a number of HCFA teams have developed discussion papers, which are in the comment and revision process. Action on these papers is expected by early Spring. Also, integration teams analyzed legislative needs for the projects, and submitted proposals for inclusion in FY 1980 legislative cycle.

One project, Common Coverage of Laboratory Services, has been completed, and implementation is expected by June 1979. This project will assure that State Medicaid agencies properly coordinate with the HCFA Health Standards and Quality Bureau (HSQB) lab certification program. It will guarantee that Medicaid pays labs only for HSQB certified tests, assuring that services for Medicaid beneficiaries meet quality standards.

Pennsylvania Fights Drug Misuse

PENNSLYVANIA RECENTLY EXPANDED its "lock-in" program, limiting beneficiaries suspected of abusing drug services to a single pharmacy. Pennsylvania "locks-in" cases, (i.e., the eligible family unit) rather than individuals. Currently, over 650 cases have been "locked-in."

Pennsylvania's fiscal agent supplies the State with profiles of beneficiaries using large amounts of drugs. Approximately 100 each month need follow-up. Individuals with patterns of abuse are asked to select one pharmacy as a source of drugs, which is noted on the Medicaid card. In addition, pharmacists receive a Medi-check list of all "locked-in" cases.

Program coordinator Jack Cope says, "Our primary goals are to assure that quality of care is delivered to beneficiaries in our charge and to curb program abuse. As an offshoot, costs will also be reduced." Beneficiary profiles are reviewed for quality of care issues by regional peer review committees. Both these committees and County Boards of Welfare make recommendations regarding "locking-in" specific cases to the program.

The program, which has been operating more than two years, is currently being evaluated for effectiveness.

Maryland Pharmacy Assistance Program

THE MARYLAND GENERAL ASSEMBLY approved a Pharmacy Assistance Program, effective January 1, 1979. For individuals whose assets do not exceed medical assistance standards by more than $1,000, pharmacy services are available through this program, which is totally State funded.

Medicaid Budget $22.3 Billion

MEDICAID EXPENDITURES in the President's budget are projected at $22.3 billion in FY 1980. Released in January, the budget shows a slowing in the rise of Medicaid costs, estimating costs will increase only 6.9% between FY 1979 and FY 1980. In addition, the budget revises FY 1979 costs estimates downward to $20.9 billion, as compared to the $21.2 billion the FY 1979 Presidential budget projected.

Of the $22.3 billion, $21.0 billion is for medical assistance payments, and $1.3 billion for administrative costs. The total Federal share for FY 1980 is projected at $12.6 billion.

Third Party Liability

NEW JERSEY SAVED $16,130,000 from July 1977 to September 1978 through improved third party liability recovery, and FY 1979 projections show the State will save at least another $12,700,000. NEW YORK also saved more than $6 million during a recent six month period through TPL activity. With MMIS and New York State's TPL initiative, this amount is expected to increase.

New York State has recently created a third party health insurance resource file in New York City. In the near future, intake workers in the City will be completing a "flagging sheet" indicating possible sources of third party coverage at time of application or redetermination. This information will then be validated and incorporated into the TPL resource file. Such a system is already in place in eight upstate New York counties.

New York State has also initiated a program that allows the Medicaid program direct access to the files of Blue Cross/ Blue Shield (BC/BS) of Greater New York, to allow for immediate liability determination. The State anticipates that this network will eventually be extended to other BC/BS districts, as well as to additional private insurance carriers throughout the State.

Trainers... Take Note!

THE MEDICAID TRAINING community is a vital program force. Training orients new staff, increases program knowledge and management skills of all staff, and encourages an effective partnership among the Medicaid program staff, providers and recipients. Training includes courses, manuals and publications, and audio-visual material -- for management staff, caseworkers, providers and recipients.

The IMM Clearinghouse collects and shares State training practices and course material. A large amount of material is already available, and a listing will be sent to States in June. In addition, the IMM is preparing a model agenda for State training and an article documenting good training and management practices for caseworkers.

A recent IMM questionaire showed State Medicaid trainers need information on types of training available, provider training, bibliographies and proposed training regulations. To meet these needs, the IMM will share ideas and references in the MMX, highlighting State training programs and other resources.

For example: PENNSYLVANIA's Income Maintenance Standards Program provides trainees with group instruction in a classroom setting, along with one-to-one supervision and on-the-job experience. The manual for this 40-day program is available from Wm. J. Condor, Director, Bureau of Manpower Planning and Development, telephone (717) 787-3239. Recommended reading is "The Social Worker as Staff Trainer," in Public Welfare, Winter 1979.

IMM needs to hear from States to keep current on training practices. Please send your training material and ideas to Susan Eberhard, MMB/IMM, Room 4046 Switzer Bldg., Washington, D.C. 20201, or call her at (202) 245-0361.

Correction

THE PRIOR MMX ANNOUNCED that MMB State assessment teams were scheduled to review each State Medicaid program at least once by the end of FY 1979 (see issue #4, page 6). The correct schedule for reviews follows:

Each State Medicaid program will be reviewed every two years. In intervening years, the top ten States (in terms of Medicaid expenditures) will undergo a thorough follow-up. This biennial review cycle begins in FY 1979.

Do We Have Your Address Right?

The IMM has updated and computerized the MMX mailing list. Please let us know if your address is not accurate, so that we can make corrections. Send the old label and changes to: Medicaid Management Exchange, IMM/MMB/HCFA, 4030 ME Switzer Bldg., 330 "C" Street, S.W., Washington, D.C. 20201.

Medicaid Management Exchange-MMX

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Medicaid Directors Conference

THE 11TH ANNUAL CONFERENCE of State Medicaid Directors was held April 2-5, 1979, at the Holiday Inn at the Embarcadero, San Diego, California. The agenda called for a discussion of current issues from both administrative and legislative perspectives. Topics included national health insurance, MMIS status and plans, Medicare-Medicaid integration, EPSDT and child health, State agency interface with fraud control units, and cost containment.

Texas Eligibility System

TEXAS ANTICIPATES A POSSIBLE $2 million saving per year from a new eligibility system designed to reduce program and administrative costs. The system is totally State administered, funded in part by Medicaid, and will contain information on 650,000 eligibles. Expected benefits are quicker eligibility determinations, fewer errors, improved management reports, and prevention of duplicate records by assigning a unique number to each eligible.

Upcoming IMM Events

Cost-Related Reimbursement for Long Term Care Seminars

Memphis, TN	4/24-26
Los Angeles, CA	9/18-20

State Eligibility Management Seminars

Colorado Springs, CO	4/24-26
Savannah, GA	5/23-25

HMOs in the Medicaid Program Seminar

Portland, OR	5/1-2

Medicaid Minimum Data Set Sessions for States

Dallas, TX	5/30-31

Third Party Liability Workshops for States

St. Louis, MO	5/22-24
Richmond, VA	6/19-21

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